

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF PENNSYLVANIA

WILLIAM KELLER,	:	CIVIL NO. 1:06-0080
Plaintiff	:	
	:	
v.	:	(Judge Conner)
	:	
JO ANNE B. BARNHART,	:	(Magistrate Judge Smyser)
Commissioner of Social	:	
Security,	:	
Defendant	:	
	:	

REPORT AND RECOMMENDATION

The plaintiff has brought this action under the authority of 42 U.S.C. § 405(g) to obtain judicial review of the decision of the Commissioner of Social Security denying the plaintiff's claims for disability insurance benefits and supplemental security income.

I. Procedural Background

The plaintiff applied for disability insurance benefits and supplemental security income on May 17, 2004, alleging disability since October 30, 2003, due to back and neck pain. (Tr. 85-87). The plaintiff requested a hearing after the state agency denied his application. (Tr. 69-74). On September 15, 2005, the plaintiff, represented by counsel, his wife, and a vocational

expert testified at a hearing before an administrative law judge (ALJ). (Tr. 24-65). On October 3, 2005, the ALJ issued an unfavorable decision. (Tr. 12-21).

The Appeals Council subsequently denied the plaintiff's request for review, making the ALJ's decision the final decision of the Commissioner. (Tr. 4-7). 42 U.S.C. § 405(g). On January 11, 2006, the plaintiff filed this action for judicial review of the Commissioner's final decision. (Doc. 1).

II. Factual Background

The plaintiff was forty-two-years old at the time of his alleged disability onset, making him a "younger" individual under the Regulations. (Tr. 19). 20 C.F.R. § 416.963(c). He is functionally illiterate and has past work experience as a roofer. (Tr. 19, 30). The plaintiff stopped working in October of 2003, after he was involved in an automobile accident. (Tr. 30).

On October 30, 2003, the plaintiff visited the emergency room with complaints of neck pain and headaches after being in an automobile accident. (Tr. 142). A physical examination detected tenderness in the cervical and thoracic spine. *Id.* An x-ray of

the cervical spine found no evidence of fracture and "mild" degenerative disc disease at C4-5 and C5-6. (Tr. 148). The attending physician diagnosed cervical strain and headaches. (Tr. 143). The plaintiff was prescribed a pain medication and a muscle relaxant and instructed to use a cervical collar and to avoid heavy lifting for two days. (Tr. 147).

A few days later, the plaintiff continued to report neck discomfort and pain to Michael Montella, M.D., his primary care physician. (Tr. 163, 182). On physical examination, the plaintiff had full range of motion in the neck. (Tr. 163). Dr. Montella noted that the October 2003 cervical spine x-ray was normal. *Id.* Dr. Montella prescribed a Medrol dose-pak and told the plaintiff to wean off of the cervical collar he had been wearing. *Id.*

A November 2003 cervical spine MRI showed mild degenerative disc disease with associated posterior vertebral spondylosis and disc bulging at C5-6 and C6-7 but no impressing on the spinal cord. (Tr. 214). There was mild disc space narrowing at C5-6 with no disc herniation or significant spinal stenosis. *Id.*

On December 10, 2003, Paul Horchos, D.O., examined the plaintiff at Dr. Montella's request. (Tr. 159, 181). Dr. Horchos described the plaintiff's cervical range of motion as "quite stiff and limited." (Tr. 160). Straight leg raising tests were negative on both legs, however, and the plaintiff's lower extremity strength was good. *Id.* Dr. Horchos prescribed muscle relaxants and recommended acupuncture to the cervical spine. *Id.*

Less than two weeks later, the plaintiff told Dr. Horchos that he had received acupuncture and that it was "somewhat helpful" in reducing his muscle spasms. The plaintiff also reported that the muscle relaxants were "very effective" at reducing his neck discomfort and spasms. (Tr. 158). Dr. Horchos' physical examination also showed improvement. *Id.* The plaintiff's sit to stand posture was "good;" his cervical posture was "slightly protracted" but "better than it was;" and side bending and rotation were "relatively full." *Id.* The plaintiff stated that he did want additional narcotics and Dr. Horchos recommended the plaintiff continue with the same medication and acupuncture program. *Id.*

Over the next three months, the plaintiff's symptoms continued to improve with treatment. (Tr. 153-57). In addition to the acupuncture and medication, in February of 2004, Dr. Horchos administered a trigger point injection into the right superior trapezei. (Tr. 154). At a March of 2004 visit, the plaintiff reported that the acupuncture and trigger point injection significantly reduced his pain and rated his pain as a two out of ten. (Tr. 153). At that visit, Dr. Horchos noted "significant improvement," including reduced neck muscle spasms and greatly improved range of motion. *Id.*

On April 28, 2004, however, the plaintiff returned to Dr. Horchos complaining of increased neck and shoulder pain; he rated his pain an eight out of ten. (Tr. 151). A physical examination was essentially unchanged since the last visit. *Id.* Dr. Horchos opined that the plaintiff had possible cervical radiculitis at C5-6 and noted that he was considering an epidural steroid injection at that site. *Id.*

On May 11, 2004, the plaintiff called Dr. Montella after a six month hiatus. (Tr. 162). He did not complain of neck pain but instead reported that he had gotten a tick on his neck while

hunting. *Id.* At a visit the following day, Dr. Horchos noted that the plaintiff was doing better than the last time he had seen him and that he had rated his pain as a two out of ten. (Tr. 149). The plaintiff reported that he was generally not doing anything but "just relaxing." He said that his neck acted up when he tried to cut the grass or go turkey hunting. *Id.* Dr. Horchos noted that a recent MRI of the plaintiff's thoracic spine showed a small disc herniation at the T6-T7 level, but Dr. Horchos opined that it was "not significant" and not causing the plaintiff pain. *Id.*

On June 22, 2004, Theodore Waldron, D.O., a state agency physician, reviewed the evidence and opined that the plaintiff, despite his impairments, could perform light work with some postural and environmental limitations. (Tr. 166-73). Based on his review of the medical record, Dr. Waldron found only "partially credible" the plaintiff's claims that he could lift nothing and could walk for only fifteen minutes. (Tr. 171).

In June and July 2004, the plaintiff underwent several acupuncture sessions. (Tr. 192-96). Between sessions, he rated his pain as no more a three out of ten; at the end of each

acupuncture session, he rated his pain as a one out of ten. *Id.*

On September 1, 2004, the plaintiff returned to Dr. Montella, ten months after his last examination and four months after his last telephone call to the physician's office. (Tr. 201). The plaintiff reported "debilitating" neck and shoulder pain which resulted in difficulty sitting and standing. *Id.* On physical examination, Dr. Montella observed marked limitation in range of motion and marked spasticity in the neck. *Id.* Dr. Montella stated that the plaintiff was "disabled given his job as a roofer" and need for muscle relaxants. *Id.* Dr. Montella completed a medical source statement regarding the plaintiff work-related abilities, in which he opined that the plaintiff could not perform the lifting, sitting, standing, or walking requirements of sedentary work. (Tr. 175-79). 20 C.F.R. §§ 404.1567(a), 416.967(a).

On November 15, 2004, the plaintiff returned to Dr. Horchos after a six month hiatus. (Tr. 190). The plaintiff reported that his neck pain was tolerable but increased with activity. He had increased pain upon neck extension but good bilateral upper extremity strength. *Id.* Dr. Horchos opined that the plaintiff

had cervical facet syndrome and recommended a cervical facet joint injection after the plaintiff told him that he wanted to be a more active individual. *Id.*

The following month, the plaintiff underwent a cervical facet joint injection. (Tr. 183-84, 189). On January 10, 2005, the plaintiff told Dr. Horchos that the injection had not decreased his pain. (Tr. 188). He reported his pain as a six out of ten, both before and after the injection. *Id.* On physical examination, the plaintiff had good range of motion in the neck and normal strength in the arms, and a good sit to stand posture. *Id.* Dr. Horchos observed significant tightness in several areas, consistent with symptoms of spasmodic torticollis. Dr. Horchos continued to prescribe muscle relaxants and recommended a botox injection to address the spasmodic torticollis. *Id.*

On January 14, 2005, Dr. Horchos wrote a letter to the plaintiff's attorney in which he opined that the plaintiff was unable to return to full or part-time work. (Tr. 186-87). In February 2005, Dr. Horchos administered a botox injection. (Tr. 185). On June 27, 2005, the plaintiff reported that his neck

pain had improved after the botox injection but that some pain had returned over the previous week. (Tr. 221). Dr. Horchos noted that the injection was starting to wear off, as the plaintiff was experiencing some tightness but had "relatively good flexibility of his neck." *Id.* Dr. Horchos noted good range of motion in the neck and a good sit to stand posture. Dr. Horchos recommended a second botox injection due to the effectiveness of the first. *Id.* The plaintiff underwent the second botox injection in July of 2005. (Tr. 216).

In July of 2005, the plaintiff reported developing a severe low back pain while mowing the lawn. (Tr. 198, 219). He had no complaints of neck pain. *Id.* On physical examination, the plaintiff had a slow and antalgic gait, muscle spasms, and limited lumbar range of motion. (Tr. 219). Straight leg raising was negative bilaterally. Dr. Horchos diagnosed low back pain with no radicular symptoms and treated the plaintiff's back pain conservatively, with muscle relaxants and nonsteroidal anti-inflammatory drugs. *Id.* A lumbar spine MRI was normal, showing no disc herniations or significant central spinal stenosis. (Tr. 208).

On August 5, 2005, the plaintiff returned to Dr. Horchos for a follow-up of his low back pain; he again did not mention neck pain. (Tr. 217). The plaintiff reported lingering back pain despite initial relief from medication. Dr. Horchos also noted some tenderness over the left posterior superior iliac spine; limited range of motion in the back; but no tenderness over the lumbar spine; normal strength and sensation; and negative straight leg raising. Dr. Horchos recommended a left sacroiliac joint injection. *Id.*

Two weeks later, the plaintiff reported back and neck pain to Dr. Horchos. (Tr. 216). The plaintiff stated that the recent botox injection had not significantly reduced his neck pain, although Dr. Horchos noted that it had only been a month after the injection, and that, given the success of the previous injection, the plaintiff would see a significant benefit once the medication became active. *Id.* The plaintiff had tightness but good range of motion in the neck. *Id.* Dr. Horchos also observed some tightness in the sacroiliac region, and noted that a sacroiliac injection would soon be administered. *Id.*

At the September 2005 hearing, the plaintiff testified that

his pain was a five out of ten on good days and a ten out of ten on bad days. (Tr. 46). He testified that he could not vacuum, take out the trash, or lift so much as a gallon of milk. (Tr. 32-33). He testified that the recent low back pain he had experienced was due to his stepping into a hole in June 2005 while putting away a lawnmower. (Tr. 37, 47).

After the ALJ issued her unfavorable decision, the plaintiff submitted to the Appeals Council a deposition from Dr. Horchos taken on October 12, 2005, less than one month after the administrative hearing. (Tr. 222). In the deposition, Dr. Horchos stated that the plaintiff's neck injury had improved, such that Dr. Horchos had not imposed any work-related limitations, within five months of the October 30, 2004 automobile accident. (Tr. 265-67). Dr. Horchos also stated that the plaintiff's condition had continued to improve, despite ups and downs, through August 2004. (Tr. 268-69). Dr. Horchos characterized his treatment of the plaintiff as conservative in nature, confirming that he had never referred him to a neurologist or orthopedic surgeon. (Tr. 280). He also confirmed that he had been paid for the January 14, 2005 letter, in which he opined that the plaintiff was unable to work, by the

plaintiff's personal injury lawyer. (Tr. 186-87, 285-86). Dr. Horchos maintained his opinion that the plaintiff was unable to return to his past work as a roofer and stated that he would have difficulty "sitting or looking over a computer for a prolonged period of time." (Tr. 255-56).

III. Disability Determination Process

The Commissioner has promulgated regulations creating a five-step process to determine if a claimant is disabled. The ALJ must sequentially determine: (1) whether the claimant is engaged in substantial gainful activity; (2) whether the claimant has a severe impairment; (3) whether the claimant's impairment meets or equals a listed impairment; (4) whether the claimant's impairment prevents him from doing past relevant work; and (5) whether the claimant's impairment prevents him from doing any other work. 20 C.F.R. §§ 404.1520, 416.920.

The ALJ determined that: (1) the plaintiff has not engaged in substantial gainful activity since his alleged disability onset date; (2) the plaintiff's back and neck pain are severe; (3) plaintiff's severe impairments do not meet or equal a listed impairment; (4) the plaintiff can not perform his past relevant

work; (5) and the plaintiff has the residual functional capacity to perform unskilled light work. (Tr. 14-20). The vocational expert testified that a significant number of jobs existed in the national economy for someone with the plaintiff's residual functional capacity, including assembly worker, packager, and non-construction laborer. (Tr. 20). Thus, the ALJ concluded that the plaintiff was not disabled under the Act. *Id.* 20 C.F.R. §§ 404.1520(c), 416.920(c).

IV. Discussion

The plaintiff's argument on appeal is that the ALJ "committed reversible error in finding the substantial and competent evidence of record insufficient to establish the plaintiff could not engage in substantial gainful employment as defined by the Social Security Act." (Doc. 4, pp. 9-10). This argument must be rejected in that it appeals to a standard of review that is not consistent with the statutory standard of review under 42 U.S.C. § 405(g).

When reviewing a decision of the Commissioner denying disability benefits, the court must determine whether the denial

is supported by substantial evidence. *Brown v. Bowen*, 845 F.2d 1211, 1213 (3rd Cir. 1988); *Mason v. Shalala*, 994 F.2d 1058 (3rd Cir. 1993). Substantial evidence "does not mean a large or considerable amount of evidence, but rather such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Pierce v. Underwood*, 487 U.S. 552 (1988); *Hartranft v. Apfel*, 181 F.3d 358, 360. (3d Cir. 1999). It is less than a preponderance of the evidence but more than a mere scintilla. *Richardson v. Perales*, 402 U.S. 389, 401 (1971).

The plaintiff argues also that the case should be remanded for consideration of new evidence, namely, Dr. Horchos' October 12, 2005 deposition. (Tr. 223-94). The plaintiff does not specify which testimony in Dr. Horchos' seventy-one page deposition would be material but instead contends it would "be as if he testified live before the ALJ."¹ (Doc. 4 at 18).

A remand pursuant to sentence six of 42 U.S.C. § 405(g) is warranted where the evidence is new, material, and the plaintiff

¹ The plaintiff points only to what he calls Dr. Horchos' "additional diagnosis of spasmodic torticollis," which, the plaintiff argues, would lend support to the plaintiff's complaints of chronic pain. (Doc. 4 at 18; Tr. 249-250). This diagnosis is not new, however. On January 10, 2005, Dr. Horchos noted symptoms of spasmodic torticollis, for which he recommended muscle relaxants and a botox injection. (Tr. 188).

has shown good cause for the failure to incorporate it in a prior proceeding. *Matthews v. Apfel*, 239 F.3d 589, 594 (3d Cir. 2001). Dr. Horchos' deposition does not meet that standard. First, it is not new. As the Commissioner points out, evidence is not "new" if it was "in existence or available to the claimant at the time of the administrative proceeding (emphasis added)." *Sullivan v. Finkelstein*, 496 U.S. 617, 626 (1990), or if it is cumulative of other evidence in the record. *Szuback v. Sec'y of Health and Human Serv.*, 745 F.2d 831, 833 (3d Cir. 1984). Here, the plaintiff's representative could have scheduled the deposition earlier so that it could have been submitted to the ALJ. The deposition was cumulative in that it merely reiterated the conclusory January 2005 opinion that was already included in the record. Second, the deposition was not material. Evidence is material if it is likely to have changed the outcome of the ALJ's decision. *Szuback*, 745 F.2d at 833. The deposition contains nothing that would have likely changed the ALJ's decision. On the contrary, Dr. Horchos' testimony that he had not imposed work-related limitations in March and August 2004, but had later opined that the plaintiff was unable to work after being paid for an opinion letter, both undermined Dr. Horchos' credibility regarding that January 2005 opinion and revealed that

the opinion did not reflect twelve consecutive months of disability. (Tr. 267-68, 285-86). Third, the plaintiff did not show good cause for failing to submit Dr. Horchos' deposition to the ALJ. The plaintiff brief offers no explanation for why he could not have scheduled Dr. Horchos' deposition before the administrative hearing. Thus, Dr. Horchos' deposition does not warrant a remand.

V. Conclusion

On the basis of the foregoing, it is recommended that the appeal of the plaintiff be denied.

/s/ J. Andrew Smyser

J. Andrew Smyser
Magistrate Judge

Dated: June 7, 2006.